

NAME:

DOB:

UT LICENSE #

UT ID#

Examiner Notes and Completed Date Stamp:

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING CONDITIONS IN THE LAST FIVE YEARS?

- YES NO **A Diabetes** Diabetes (high blood sugar, sugar diabetes you control with diet, medication or insulin) or hypoglycemia or other metabolic condition etc., which may interfere with driving safety?

- YES NO **B Cardiovascular** Heart condition, with or without symptoms (heart attack, heart surgery, irregular rhythm, general heart disease) within the last five years; or hypertension (high blood pressure) unable to be controlled with medication?

- YES NO **C Pulmonary** Pulmonary (lung) condition (asthma, emphysema, passing out from coughing, etc.) shortness of breath which has required treatment?
 YES NO Is an inhaler the only medication prescribed for this condition?
 YES NO Are you required to use supplemental oxygen while driving?

- YES NO **D Neurologic** Neurological condition (stroke, head injury, cerebral palsy, multiple sclerosis, muscular dystrophy, Parkinson's disease, etc.) which may interfere with driving safety?

- YES NO **E Epilepsy** Seizures or other episodic conditions which include any recurrent loss of consciousness or control?
 YES NO Commercial: Anytime during your life.

- YES NO **F Learning and Memory** Learning and memory difficulties observed personally or reported to you by others?

- YES NO **G Psychiatric** Psychological condition (severe anxiety, severe depression, severe behavioral mood conditions, schizophrenia, etc.) or other conditions for which hospitalization has occurred or been recommended by a physician or other mental health professional?

- YES NO **H Alcohol and Drugs** Excessive use of alcohol and/or prescription drugs, or use of any illegal drugs; or treatment or recommendation for treatment of alcohol use or chemical dependency?

- YES NO **I Vision** Do you wear glasses or contact lenses for driving?
 YES NO Is your visual acuity worse than 20/40 in the better eye, even with corrective lenses?
 YES NO Do you have degenerative or progressive eye condition?
 YES NO Have you experienced a decrease in peripheral (side) vision?

- YES NO **J Musculoskeletal Chronic Debilities** Loss or paralysis of all or part of an extremity; or onset of a general debilitating illness requiring treatment?
 YES NO New or changed in the past 5 years?
 YES NO Present longer than 5 years?

- YES NO **K Alertness or Sleep Disorders** Do you have a condition that produces abnormal sleepiness (sleep apnea, narcolepsy, etc.?)

- YES NO **L Hearing Impairment** Only if you are a Commercial driver – no hearing requirements have been established for Regular Operator license.

- YES NO **Balance (ENT Problems)** Have you experienced any sudden vertigo or infection of the inner ear (vestibular neuronitis or labyrinthitis?)
- YES NO **Other** Other health problems or use of medications which might interfere with driving ability or safety? Please explain:



PLEASE STOP AND TAKE THE COMPLETED FORM TO AN EXAMINER